



Office of Health Facilities

Application for Assisted Living Residency

Reference Guide for New Applicants

Let's begin!

Log In to the platform

1 Enter your username and password.

2 Click the Log In button.

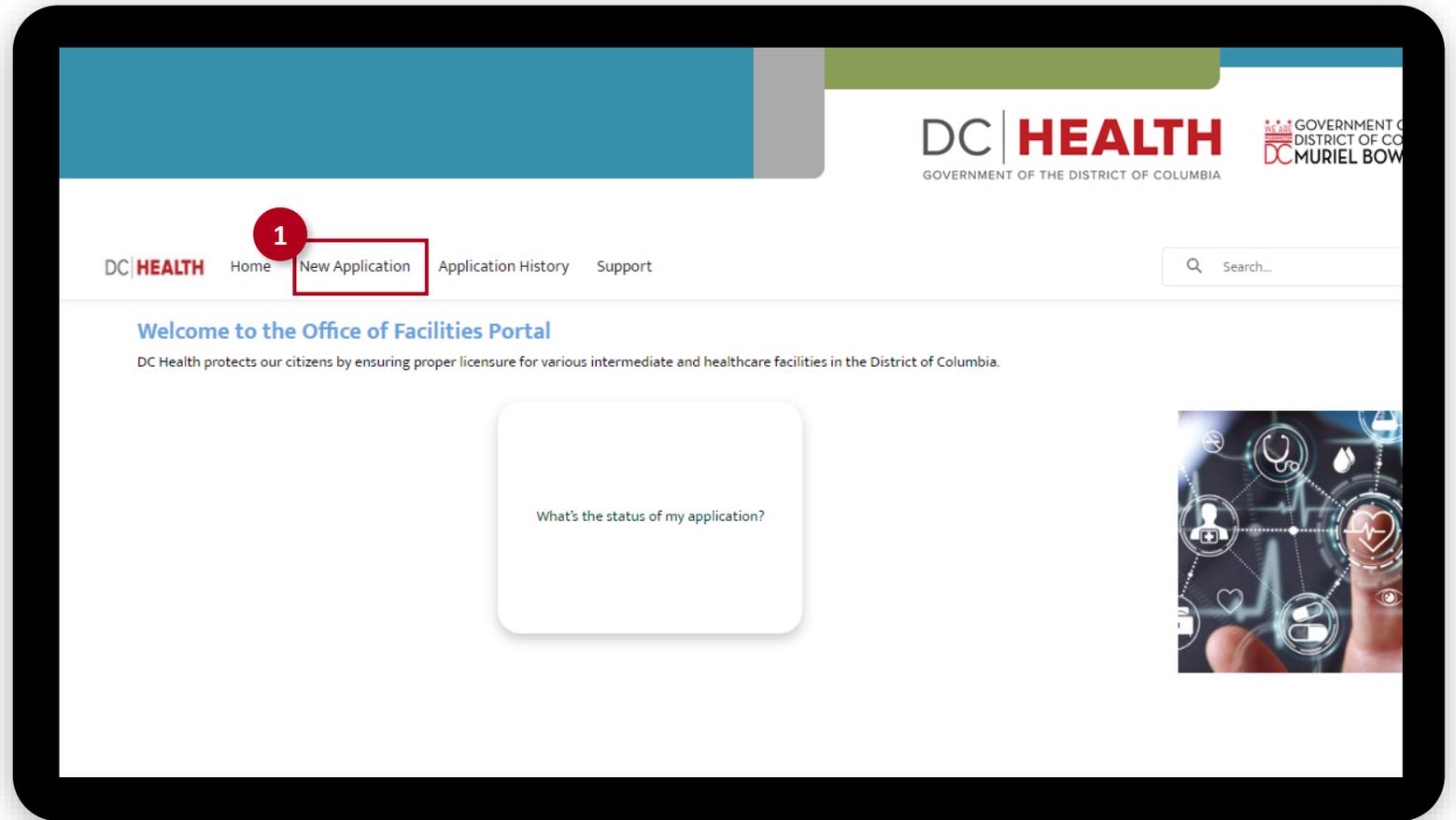


TIP: If you don't have an account click the **Create New Account** link.

The screenshot shows the DC Health login page. At the top right, there is a header with the DC Health logo and the text "GOVERNMENT OF THE DISTRICT OF COLUMBIA" and "MURIEL BOWSER, MAYOR". Below the header, the page is titled "DC HEALTH" and "Welcome to the Office of Health Facilities Portal". The main content area contains a login form with two input fields: "TestUser17" for the username and "....." for the password. A blue "Log in" button is positioned below the password field. To the right of the login form, there is a section titled "Login or Create an Account to:" with a list of options: "Apply for a new medical facility license", "Renew an existing medical facility license", "Check the status of past applications", and "Seek support related to interactions with this office". Below this, there is a section titled "About DC Health" with a paragraph of text. At the bottom of the login form, there are two links: "Forgot your password?" and "Forgot username?".

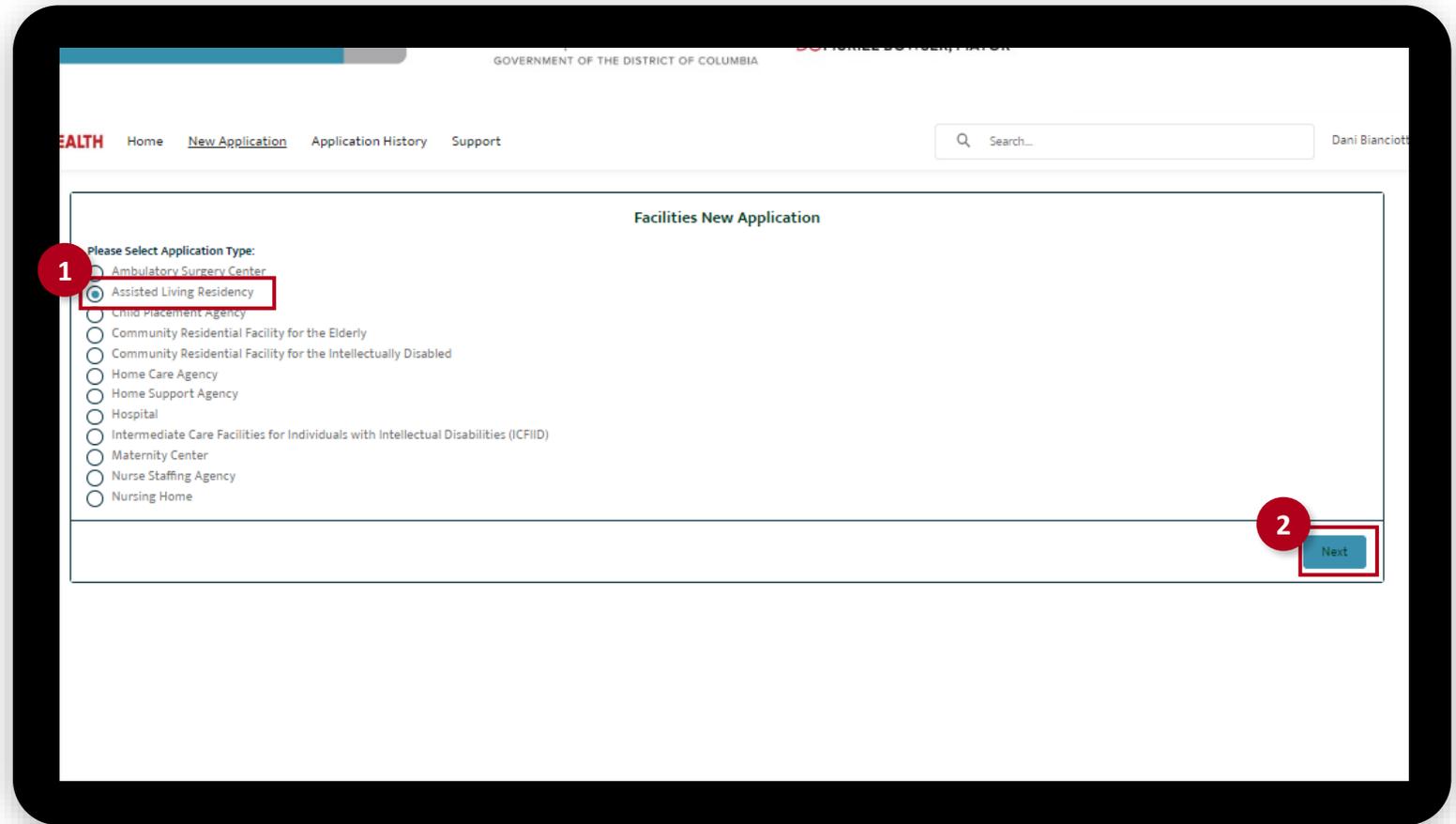
Navigate to the New Application screen

- 1 Once you Log in to the Office of Facilities Portal, click the **New Application** tab.



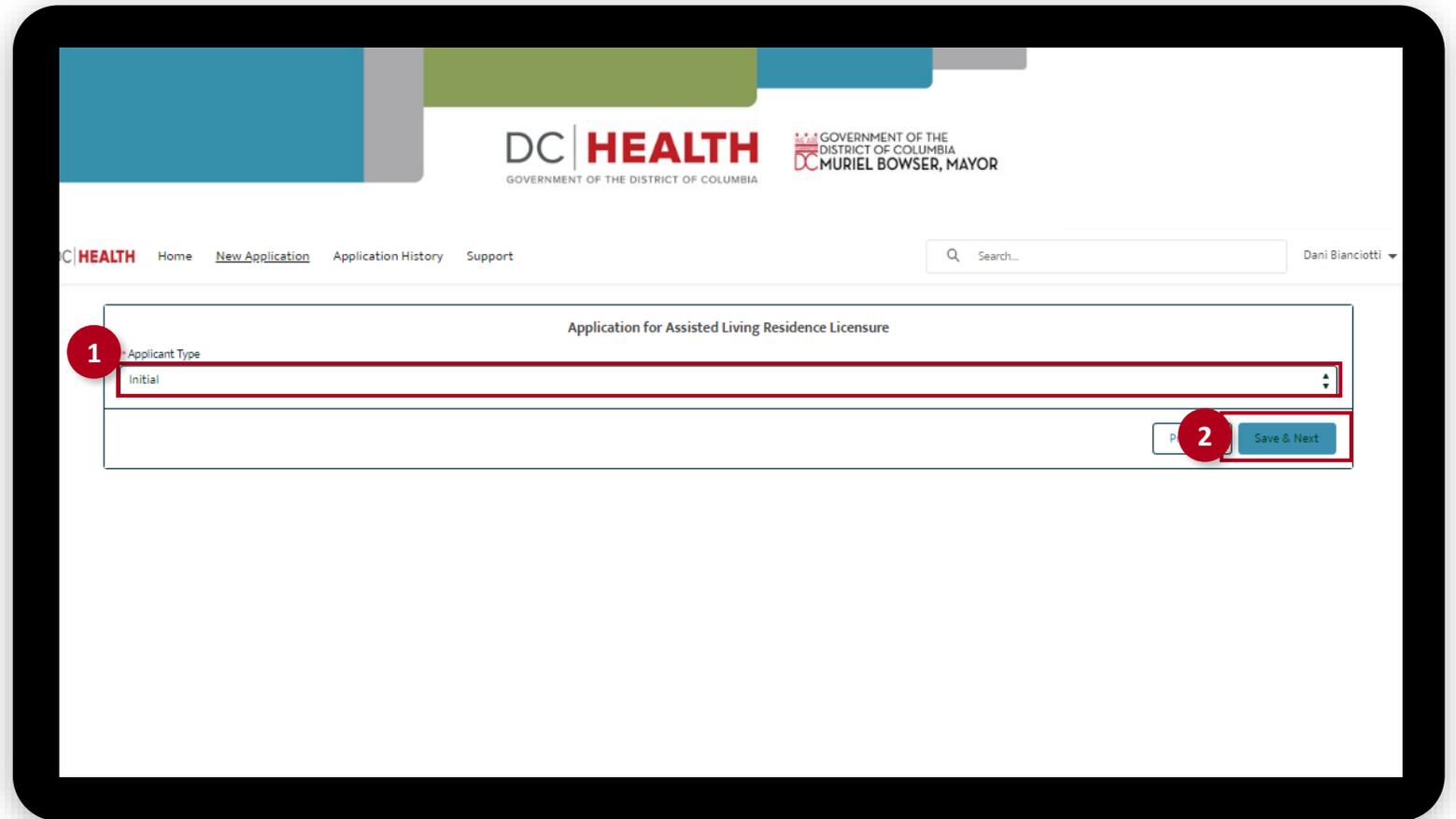
Select the Facilities New Application

- 1 Select the Assisted Living Residency option from the list.
- 2 Click the Next button.



Select the Applicant Type

- 1 Select the **Initial** option from the drop-down list.
- 2 Click the **Save & Next** button.



Fill out the Agency Information

- 1 Fill out all the required fields.
- 2 Click the Save & Next button.

Agency Information

* Name of the Residence: Braulio Little

* Street Address: 619 Bartell Locks

* City: Fort Jennyferchester

* State: NY

* Zip Code: 32705

* Telephone: 419-845-6114

* Fax Number: 466

* Ward: Zackery Lindgren

If mailing address is different from street address

Contact Person:

* First Name: Lindsey

Middle Name: Mohamed Hoeger

* Last Name: Erdman

* Street Address: 2676 Considine Junction

* City: Kuphalton

* State: NJ

* Zip Code: 65375

* Telephone: 860-657-6262

* Email: your.email+fakedata53318@gmail.com

Save & Next

The fields marked with * are mandatory and must be filled out to continue.

Fill out the Licensee and Bed Fees Information

- 1 Fill out all the required fields.
- 2 Click the **Save & Next** button.

HEALTH Home [New Application](#) Application History Support

Search: Veit omnis molestiae voluptates autem quos impedit in Dani Bianciott

License and Bed Fees

* Please indicate Resident Capacity Standard License Fee:1005

100

If this is a renewal application mailed less than 90 days prior to license expiration, enter the late fee amount on line here:

Increase in Residents Capacity

Total Licensed ALR Residents Total number of residents to be increased

Location of Additional ALR Residents

Pre **2** Save & Next



TIP: If it is a **Renewal** application 90 days prior to license expiration fill out the required field. If there is an **increase in Residents Capacity**, you can fill out the information in this page.

*The fields marked with * are mandatory and must be filled out to continue.*

Fill out the Applicant/Owner Information

- 1 Fill out all the required fields.
- 2 Click the **Save & Next** button.

HEALTH Home [New Application](#) Application History Support

Veit omnis molestiae voluptates autem quos impedit in Dani Bianciotti

Applicant/Owner Information

Applicant is an:
Individual

Other

Corporation Status:
For Profit

The property and buildings are:
Owned

Please attach documentation regarding the property owner. Documentation should include the following: Name, Address, Telephone Number & Email Address.

Upload Files Or drop files

* Is the agency managed by someone other than the applicant?
No

Please attach documentation regarding the person(s) who has/have responsibility for the residence's financial operation. Documentation should include the following: Name, Address, Telephone Number & Email Address.

Upload Files Or drop files

Prev **2** Save & Next



TIP: If needed, use the **Upload Files** button to attach needed documentation.

*The fields marked with * are mandatory and must be filled out to continue.*

Fill out the 5% Ownership Interest Information

- 1 Fill out all the required fields and attach needed documentation using the **Upload Files** button in each section.
- 2 Click the **Next** button.

5% Ownership Interest

Corporations Only: Please attach documentation regarding each person having at least a 5% ownership interest in the corporation which owns the ALR business (attach an addendum to the application, if necessary). Documentation should include Name, Address, Telephone Number, Email Address and Percent of Ownership.

Or drop files

Please attach documentation for any facility or other entity licensed by the District of Columbia or another state to provide health or assisted living care with which the administrator or any person listed in this section has been affiliated through ownership or employment within the last 5 years. Documentation should include Facility name, type, address, dates of affiliation, Certificate of Occupancy and whether the affiliate is an employee or owner.

Or drop files

If the facility or other entity closed or ceased to operate due to financial problems; had a receiver appointed; had its license denied, suspended or revoked; was subject to a moratorium on admissions; or had an injunctive proceeding initiated against it, please provide a detailed description and explanation of the occurrence. Attach additional sheets if necessary.

Or drop files

Adverse Actions?

No

Does any owner, partner/associate/firm member, officer, or director have at least a 5% ownership interest in any professional service, firm, association, partnership, or corporation providing goods, leases, or services to the facility?

No

Please provide documentation for any professional service, firm, association, partnership, or corporation. Documentation should include business name and address

Or drop files

Nature of Business Relationship

Has the applicant been terminated, permanently suspended, or excluded from the Medicaid programs?

No

Has any officer, partner/associate/firm member, director, or person owning at least 5% or more of the facility ever been convicted of any offense prohibited by section 435.04, F.S.?

No

Please attach documentation regarding any References. Documentation should include the following: Name, Address, Telephone Number & Email Address.

Or drop files

The fields marked with * are mandatory and must be filled out to continue.

Fill out the Administrator's Information

- 1 Fill out all the required fields.
- 2 Click the **Save & Next** button.

HEALTH Home [New Application](#) Application History Support

Search: Eaque nobis porro qui dignissimos incidunt qui et quis c... Dani Bianciotti

Administrator's Information

First Name: Verona Middle Name: Mellie Gottlieb Last Name: Green

Administrator Start Date: Oct 1, 2019 High School Diploma/GED?: Yes

Served as Direct Care Provider or Admin?: No Administrator of More than this ALR?: No

If yes, please attach documentation including the name of the other facilities and corresponding license number.
Upload Files Or drop files

5% Owner Information

Surety Bond: Upload Files Or drop files

Representative Payee/Power of Attorney?: No

Relationship to ALR: Quasi sit distinctio aut ab voluptas dignissimos.

Save & Next

 **TIP:** If needed, use the **Upload Files** button to attach needed documentation.

The fields marked with * are mandatory and must be filled out to continue.

Upload the Insurance Coverage

- 1 Select **Yes/No** from the drop-down menu.
- 2 Click the **Next** button.

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

HEALTH Home [New Application](#) Application History Support

Ab ea nihil nobis commodi est nam voluptatibus ipsa. Dani Bian

1 Insurance Coverage

* Does the facility have Liability insurance?

Yes

please provide documentation of insurance.

[Upload Files](#) Or drop files

2 Next



TIP: If needed, use the **Upload Files** button to attach needed documentation.

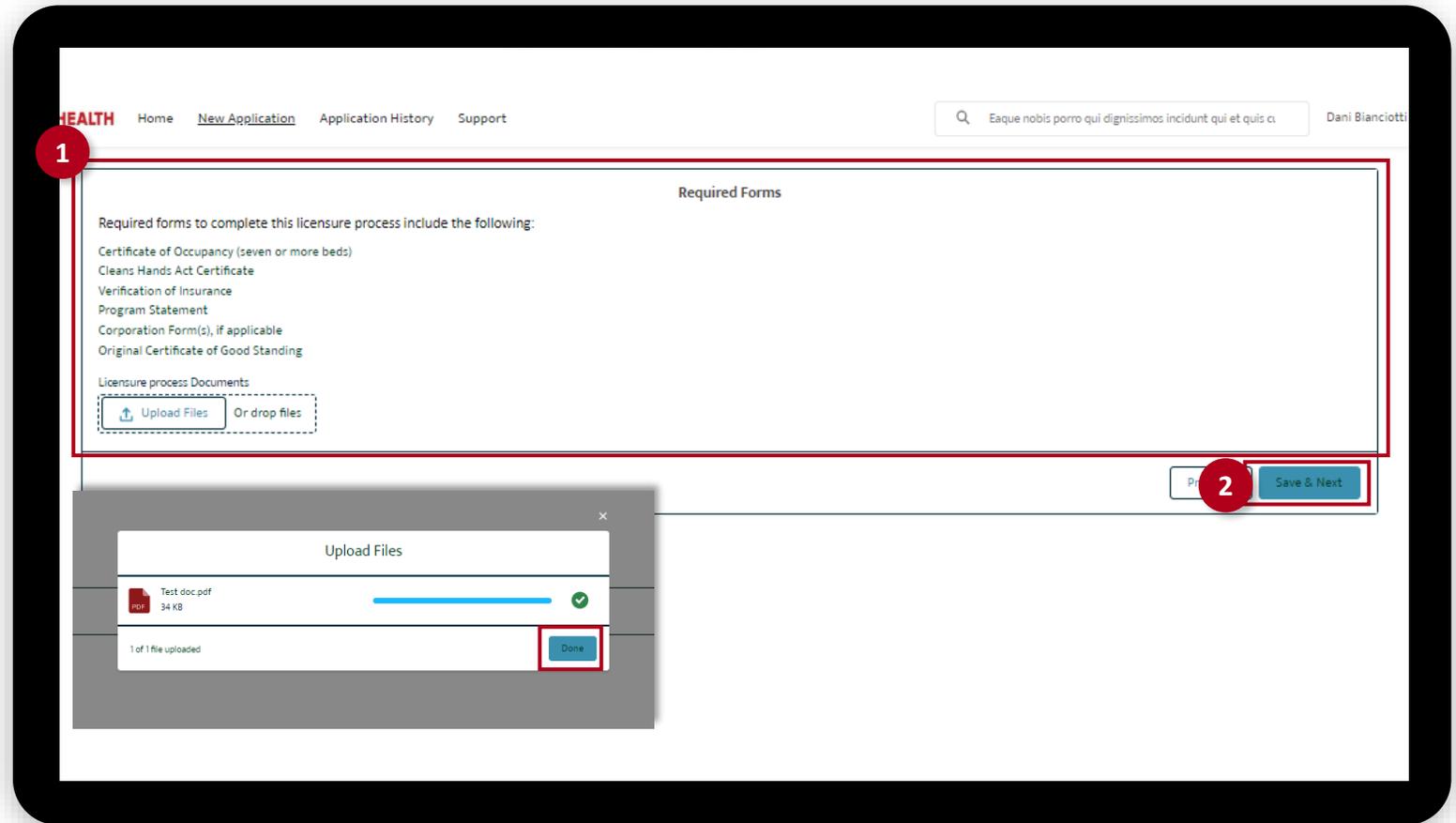
*The fields marked with * are mandatory and must be filled out to continue.*

Upload the Required Forms

- 1 Use the **Upload Files** button to attach required forms:
 - Certificate of Occupancy
 - Clean Hands Act Certificate
 - Verification of Insurance
 - Program Statement
 - Corporation Form(s), if applicable
 - Original Certificate of Good Standing

Once the checkmark appears in the pop-up click the **Done** button.

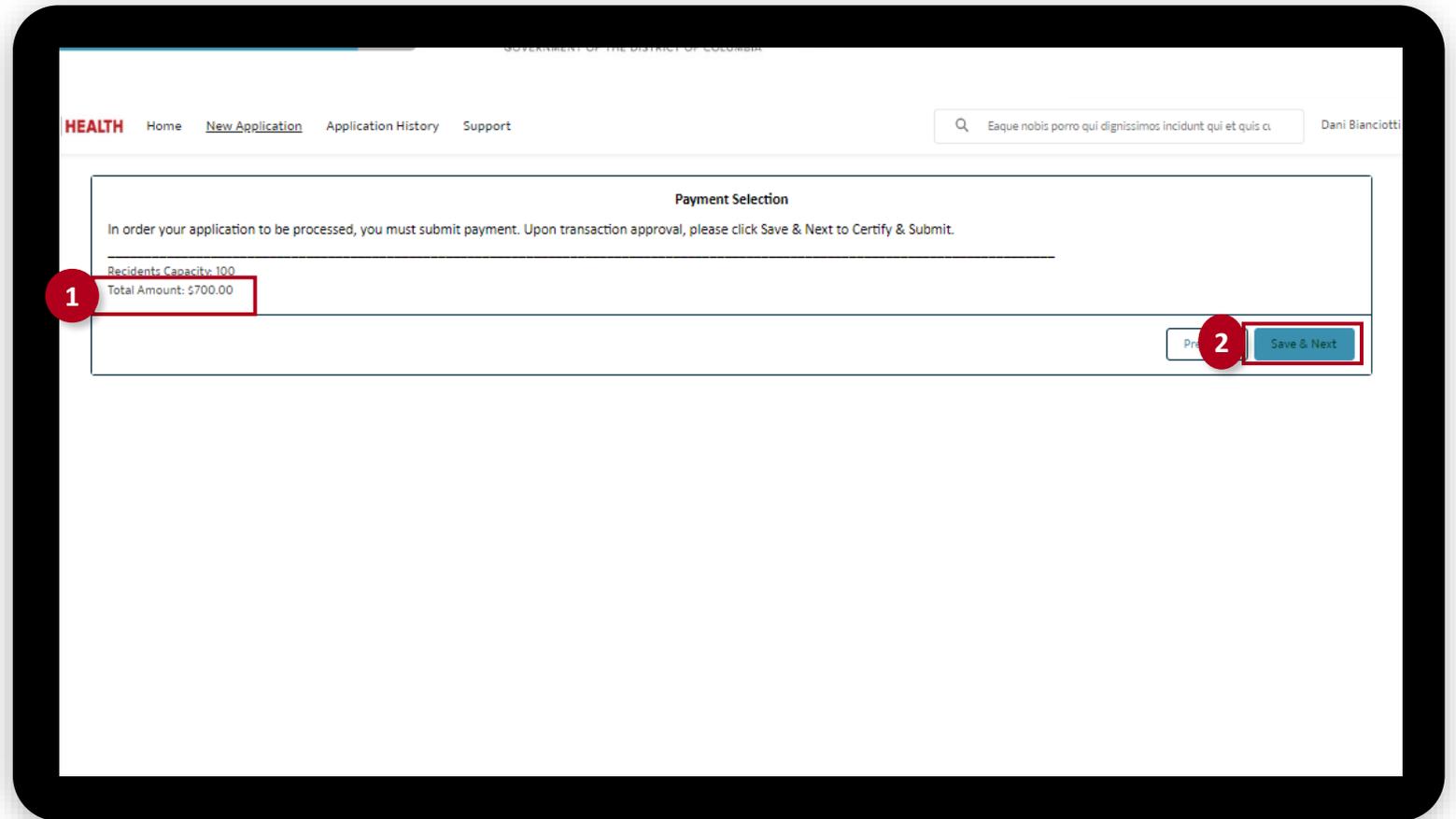
- 2 Click the **Save & Next** button.



The fields marked with * are mandatory and must be filled out to continue.

Payment Selection

- 1 Check if **Total Amount** is correct.
- 2 Click the **Save & Next** button.



The fields marked with * are mandatory and must be filled out to continue.

Payment Wizard



1 Fill out the **Billing Address** and **Payment Info** fields.

2 Click the **Pay** button.

HEALTH Home [New Application](#) Application History Support

Id qui qui ad sed omnis voluptatem alias. Dani Bianciotti

Payment Wizard

Please complete the payment for your application using the form below. Click "Pay" when you are done inputting your payment details. If you are unable to pay at this time, you may exit this saved draft and return to it in the "Application History" tab of the portal header later.

After your payment has processed, click "Next" below to certify and submit the application. Your application will not be reviewed until these steps have been completed.

1

Billing Address	Payment Info
27 Deckow Drive	Colt O'Reilly
3261 Cesar Garden	3714 496353 98431
Borershire	10 / 25
Utah ?
17812-0633	

2 Pay \$700.00

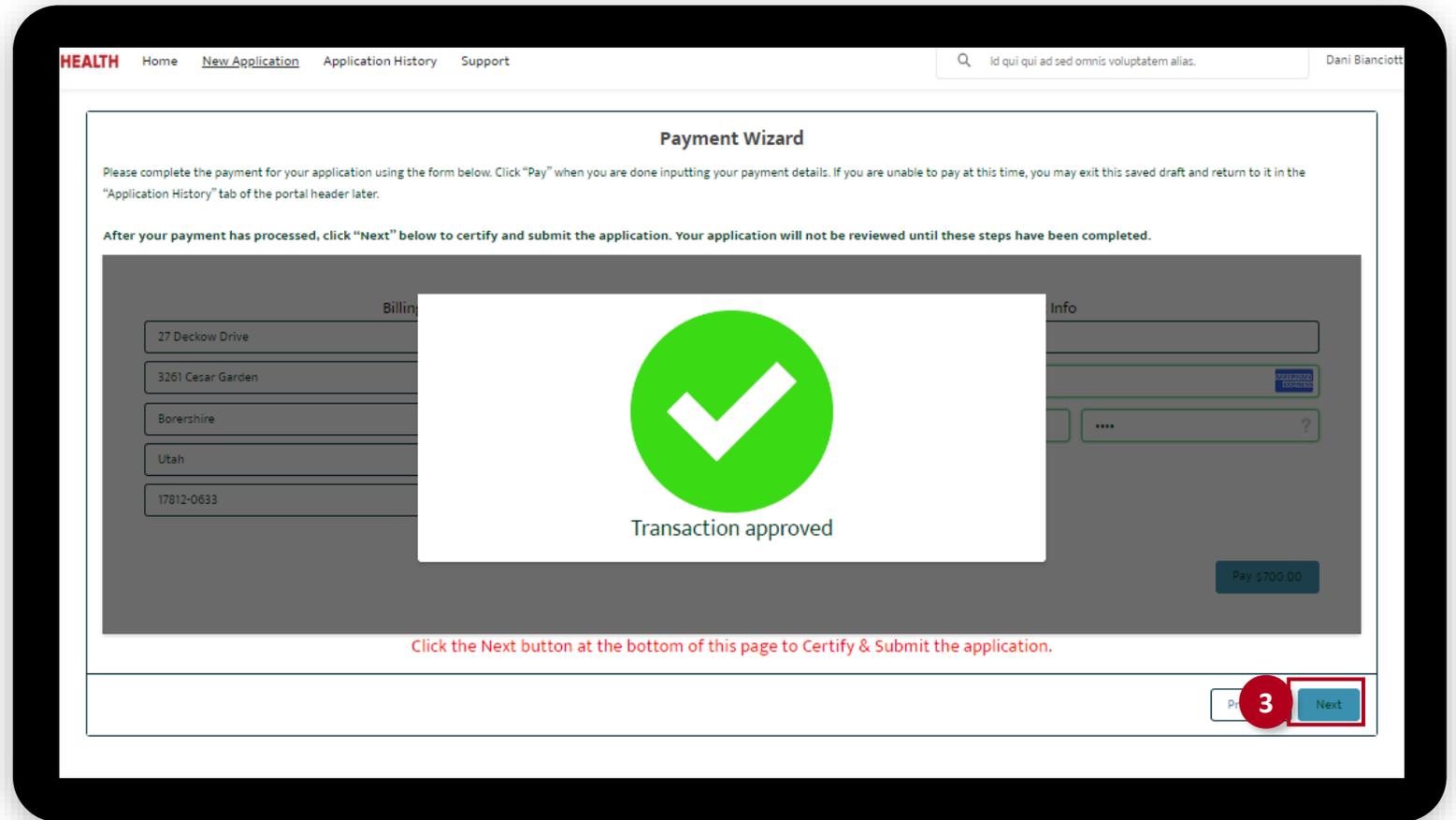
Click the Next button at the bottom of this page to Certify & Submit the application.

Previous Next

Payment Wizard



- 3 Once the **Transaction** is approved, click the **Next** button.



Certify and Submit

- 1 Fill out the Name field.
- 2 Click the Submit button.

DC HEALTH
GOVERNMENT OF THE DISTRICT OF COLUMBIA

GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER

ALTH Home [New Application](#) Application History Support

Ut atque nulla voluptatum voluptatem atque dolor et tol

Certify and Submit

By clicking the submit button below, you are acknowledging that you are providing information for an official record and that the information you are supplying is true. By submitting this information, you understand that knowingly and willfully making a false statement on an official record may result in action against your license, registration, or certification and criminal penalties*. This information will be held confidential by the Department of Health.

*(a) A person commits the offense of making false statements if that person willfully makes a false statement that is in fact material, in writing, directly or indirectly, to any instrumentality of the District of Columbia government, under circumstances in which the statement could reasonably be expected to be relied upon as true; provided, that the writing indicates that the making of a false statement is punishable by criminal penalties or if that person makes an affirmation by signing an entity filing or other document under Title 29 of the District of Columbia Official Code, knowing that the facts stated in the filing are not true in any material respect or if that person makes an affirmation by signing a declaration under § 1-1061.13, knowing that the facts stated in the filing are not true in any material respect;
(b) Any person convicted of making false statements shall be fined not more than the amount set forth in § 22-3571.01 or imprisoned for not more than 180 days, or both. A violation of this section shall be prosecuted by the Attorney General for the District of Columbia or one of the Attorney General's assistants.

1 I am electronically entering my name on this form, I attest that all statements are true and accurate.

Name
Myrtice Batz

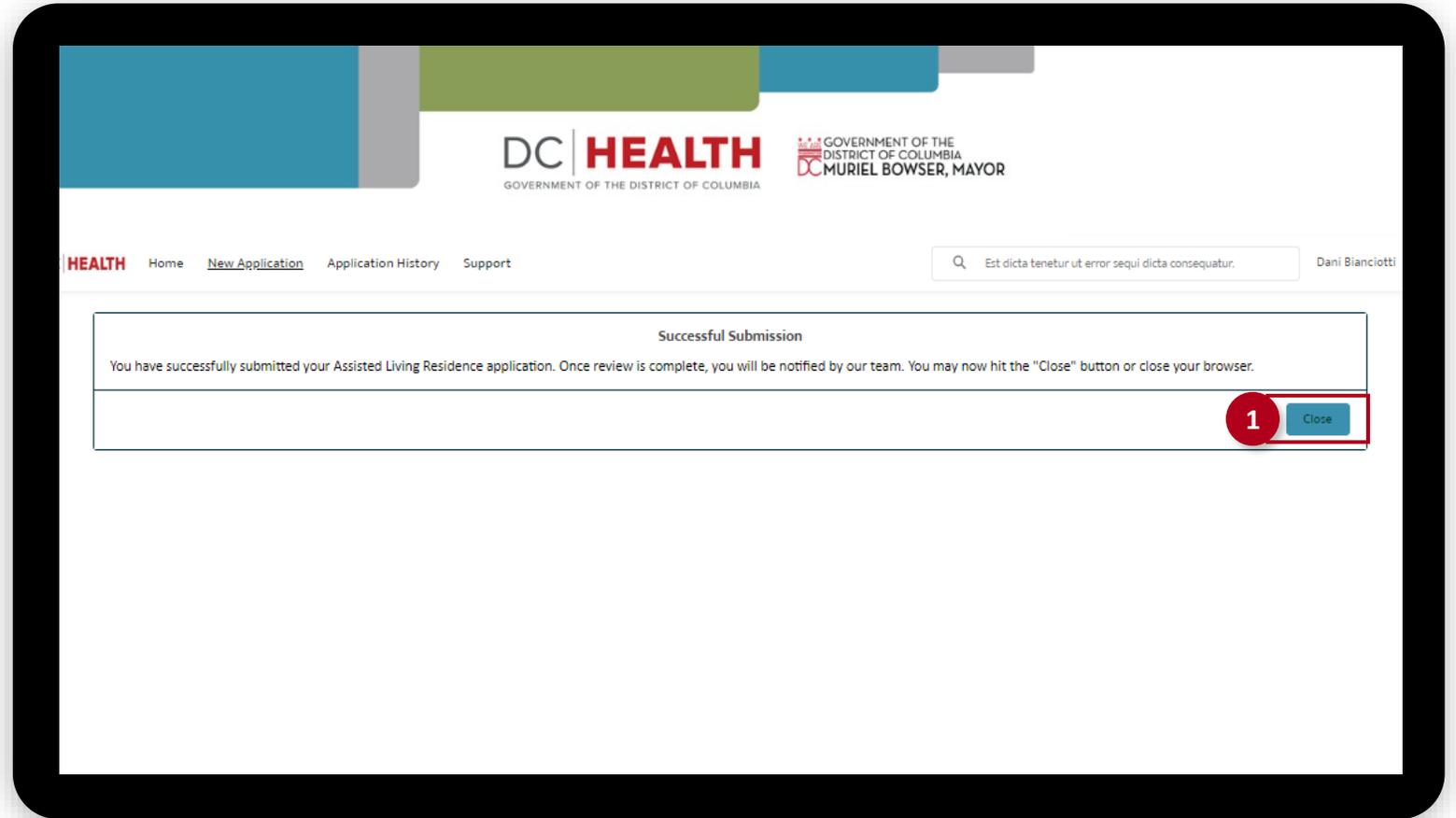
Date
January 24, 2023

2 Submit

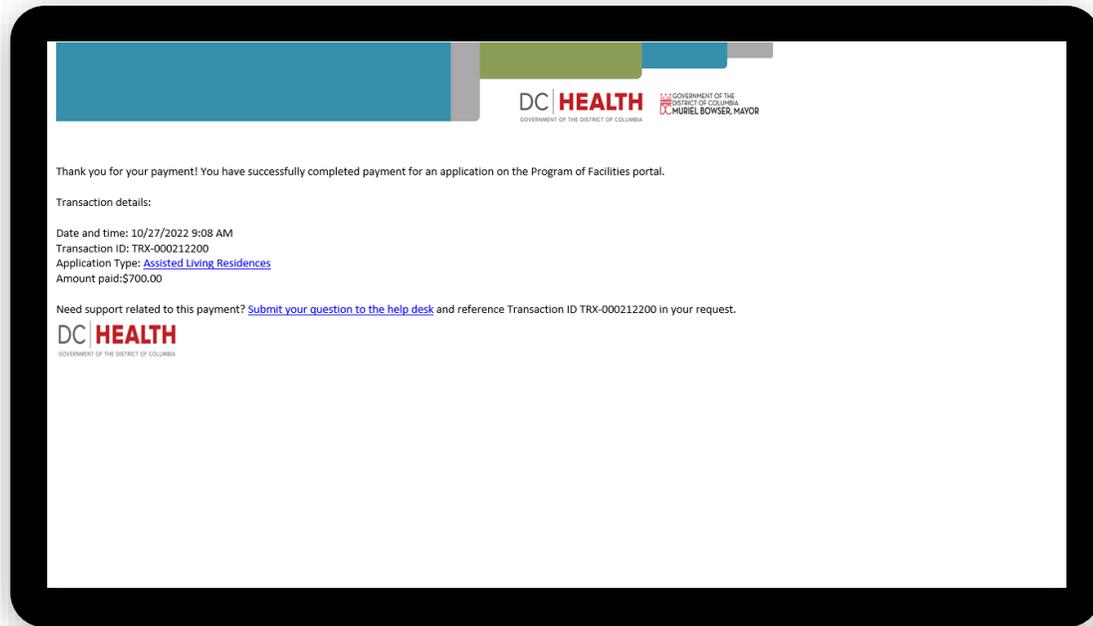
The fields marked with * are mandatory and must be filled out to continue.

Close the Application

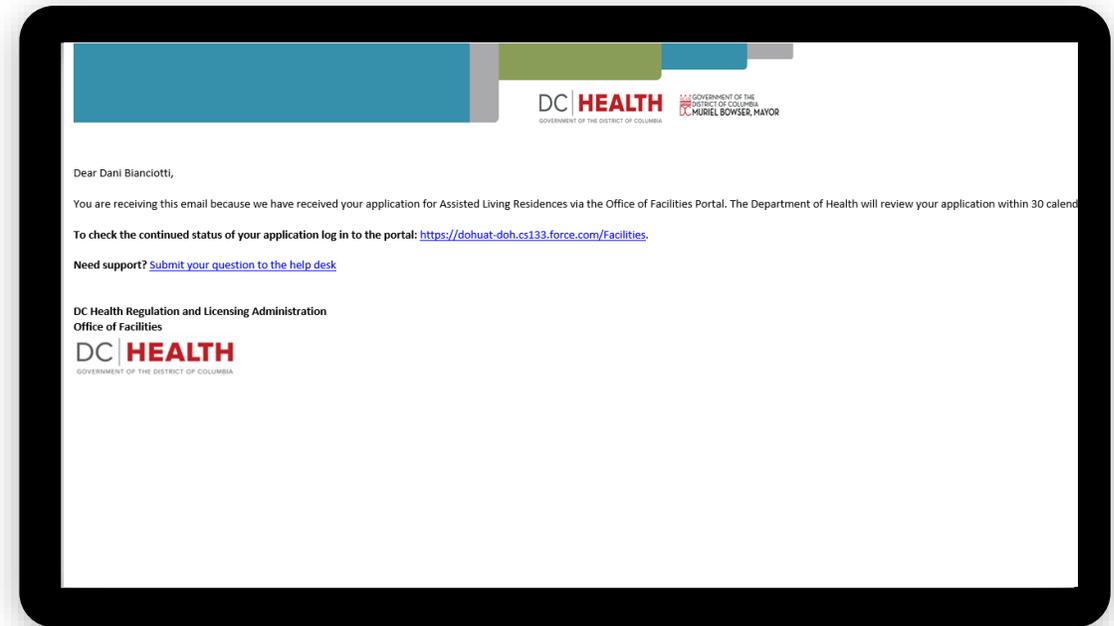
- 1 You have finished submitting your application. Click the **Close** button.



E-mail Confirmation



1 Check if you have received confirmation of payment.



2 Check if you have received confirmation for your application.

Thank you!